"O N S H E L L - S H O C K"

and its Relation to certain Hysterical Phenomena observed on Active Service, with an Account of the Treatment of such Phenomena by Hypnotic Suggestion.

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"ON SHELL-SHOCK"

and its Relation to certain Hysterical Phenomena observed on Active Service, with an Account of the Treatment of such Phenomena by Hypnotic Suggestion.

In the course of my work as mental specialist to a group of large Base Hospitals in France, I have had the opportunity of treating and studying a great number of cases of shell-shock, and of functional nervous disorder of various kinds. Many of the cases showed what are generally known as "hysterical" phenomena, and I propose to limit myself in this paper to an account of some such cases which I treated by means of hypnotic suggestion. As, however, the majority of these phenomena occurred in intimate connection with shell-shock, and as there is a prima facie case in support of the view which regards such phenomena purely as symptoms of it, some discussion of this already much debated condition will first be necessary, both for the above reason, and on account of its comparative novelty and intrinsic interest.

The factors at work in the production of the condition may be grouped under the headings of Physical and Psychic, and can be detailed as follows:--

Physical. 1. Actual visible trauma from shell fragments, etc., or from earth or sandbags in buried cases.

2. "Commotio cerebri" from the violent aerial disturbance produced by the explosion, and perhaps aided by the concussion from being buried, or thrown violently to the ground; physical injury, that is, to the central nervous system.

Psychic. 1. The mental and emotional condition of the patient at the time of the occurrence.

2. His past nervous and mental history, his pre-dispositions and his general mental make-up.

The relative importance of these factors is still a matter of much discussion. It is, of course, impossible to separate them completely and to consider them as distinct and apart, but speaking broadly, one view attaches paramount importance to the psychic factors, while the other, though not disputing or denying their importance, seeks to explain many of the symptoms by considering them as the results of physical trauma; concussion, or "commotio cerebri". These views have been elaborated, on the one hand, by Col. Myers, (1), and on the other by Major Mott, (2). It will be well to discuss in more detail the factors mentioned above and to give the views of others who have written on the subject.

Physical. 1. Visible injury. It is agreed on all sides that the most severe forms of shell shock can be, and frequently are, produced without any visible signs of injury whatever. My data are at present insufficient to warrant any deductions from this fact, but I may mention two points which are at least suggestive, namely, that out of many patients wounded as a result of shell explosion, I have seen hardly any cases of shell shock, and that out of the hundred and fifty cases of shell shock on which this paper is based, only one showed any signs of physical injury--- a few scratches on the face.

2. Concussion, or "commotio cerebri", etc. It is on this/

this point that discussion is mainly centred at present. The remarkable results which can be produced on buildings, etc., by sudden atmospheric disturbance alone are strikingly described by Lynn Thomas (3) in a paper to which I shall refer later, and of course, the opinion that sudden air compression can prove fatal has long been held. An interesting personal experience in this connection was recorded some time ago by a military man in a medical paper (4). There is a certain amount of indefiniteness shown by writers in stating exactly how the fatal effect is produced. In his discussion of the point at a meeting of the Royal Society of Medicine, Major Mott said, "In some cases the forces generated by the high explosives may cause such a disturbance of functions of the whole central nervous system as to arrest the activities of the vital centres, especially of the medulla, and cause instantaneous death," (5), which does not take us very much further. It has been suggested that the fatal effects may be explained on the principle of caisson disease, the sudden increase of pressure, causing the blood to hold an excessive amount of gases in solution. When the pressure is removed the excess is released with fatal effects. That such sudden deaths occur, whatever the actual cause, is undoubted. An interesting case within my own knowledge is that of an officer who was killed by the sudden explosion of a shell in his immediate neighbourhood. He was under cover at the time and sustained no visible injury whatever, but death was instantaneous, and his pocket barometer

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was found to be registering its highest possible figure. Such cases of sudden death are not common and the opportunities for making post mortem examination upon them hardly ever arise. In fact the absence of post mortem evidence, which is almost unavoidable, as the cases are either fatal immediately, or not at all, is the greatest difficulty with which those who support the view of physical injury to the central nervous system have to contend.

Psychic. That physical injury to the nervous system may play a part, and an important part, in the production of the symptoms I am very ready to admit. I will say indeed that without physical injury, or at least physical stimulus, the condition would never have arisen, but from my experience I am bound to conclude that the all-important factors in determining the severity, the symptoms, and the course of the disease are the psychic ones. The strongest argument and the most obvious one in support of this view is the extraordinary variety of symptoms presented by patients suffering from shell shock who are exposed to shell fire under as nearly as possible parallel conditions. After making every allowance for the doctrine of individual variability it is hard to explain such a situation as the following:-- A shell bursts in the neighbourhood of a dozen men. Of those who are unwounded, one may die instantly, one may be merely dazed and frightened, one may become unconscious, and remain semi-comatose for days, one may show, either at once or later, any of the bewildering variety of hysterical phenomena

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of which I am about to speak, while many may suffer from no ill-effects whatever. All these men were exposed to as nearly as may be the same physical forces and atmospheric disturbance. We must surely look to the individual pschology of each man to explain the great diversity of effects.

Writers have frequently stated that in cases in which unconsciousness supervenes immediately,--cases that is, in which the patient has no time to realise what is happening to him,--the psychic factors must obviously be excluded, and the resulting symptoms be regarded as due to simple concussion. In the paper to which I have referred, Lynn Thomas states, "It is manifest that it is only in the type of shell shock in which a latent period occurs before the onset of the state of unconsciousness, that the psychic centres can exert any influence upon the nervous machinery of the emotions." As far as I understand this statement I disagree with it entirely. A large number of my cases were rendered instantly unconscious, before they realised they were being shelled at all. All they knew was that they had been told they had been thrown violently to the ground and remained unconscious till they reached the field ambulance or clearing station. Among these, however, there were some of my most remarkable cases of hysterical phenomena, and as a whole they showed a combination of symptoms utterly different in their nature and variety from those observed as a result of brain concussion in civil life, however produced. Strangely enough, the case in connection with which Lynn Thomas makes/

makes the above statement was that of a collier who experienced a shock with no "latent period", but on recovering consciousness was found to be suffering from deaf-mutism, a "symptom of concussion of the brain" from which he suffered for seven years till cured by a second underground explosion, this time with a latent period. In the meantime, however, he had been allowed to marry a congenital deaf-mute! It is, of course, as Major Mott points out (6) very difficult to decide whether a patient was truly unconscious, or whether his unconsciousness of events is not wholly or partially due to the blotting out of his recollection. I have been fully alive to this difficulty, and have as far as possible convinced myself of the real and complete nature of the unconsciousness in the cases referred to above. It is surely contrary to what we know of psychological mechanisms to assume that the psychic factors can play no part in cases in which concussion is immediately followed by unconsciousness, the patient having "no time to think." It is certainly contrary to clinical experience.

In what way does the normal individual react in civil life to some such sudden shock as, for example, a motor cycle accident? It is a matter of common knowledge that he is shaken and upset, "shocked" as we say, out of all proportion to the physical injuries received. With trifling injuries he will appear for hours, or possibly days, white, nervous, tremulous and perhaps a little dazed. Further, he has "lost his nerve," to a greater or lesser extent, and it may be weeks, months or even years before he/

he regains his old confidence. What has caused his symptoms? Not the actual injuries received, which may be of the most trifling description. Subject him to the same injuries in the course, say, of a football match, and he will not notice them. Again, give him full knowledge of exactly what is coming, and subject him to it as he sits in his chair, and he will ignore it, but let him <u>just escape</u> his cycle accident by regaining control of his machine when all hope seemed lost, and will he not present, though possibly in a slighter degree, many of the symptoms mentioned above, though no injury has been inflicted upon him at all? This is an illustration of the immense importance of the first of the psychic factors---the mental and emotional condition of the patient at the time of the occurrence. There may be accidents which render a patient insensible before he can put to himself, even subconsciously, the query:-- "What is going to happen to me?", or "What is happening to me?", and before such a query can evoke its reactions of fear, self-preservation, etc., though my conviction is that such are very much more rare than is supposed, in connection with shell explosion. In any case, however, it is to be remembered that a great majority of the patients have daily cause to put to themselves such queries as the above, have been exposed to more or less severe and constant nervous strain for weeks or months prior to the actual "shock", and are, in fact, in a state of such nervous expectancy at the moment of its occurrence, as is only to be appreciated by those who have themselves been under shell fire.

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All observers seem agreed upon the importance of the second psychic factor:-- heredity, pre-disposoitions and general mental stability---in determining the severity and nature of the symptoms. It bears directly upon the cases whose treatment I am about to describe, and its importance is illustrated by the statistics I shall give. It raises the very difficult problem of what group of symptoms is to be regarded as fundamentally the syndrome of shell shock and what symptoms are to be considered as complications or extraneous accompaniments, depending upon the individual peculiarity of the patient. There will always, of course, be great individual variation with regard to every symptom, and the more weight we attach to the psychic factors concerned the more will we be prepared to find such variation. But in many predisposed cases the symptoms become, at a point entirely and completely individual. Patient A shows certain symptoms which patient B not only does not show, but could not show, whatever the severity of his condition is or may have been.

Patient A is so constituted and predisposed that under sufficient stimulus he will exhibit some particular and individual symptom of an hysterical nature. Why he should be so constituted is another question, the answer to which may be sought for in his family or personal history, in his circumstances, and habits of body and mind, or, along psychanalytic lines, in the depths of the mental conflicts of a lurid and forgotten past. The fact remains, however, that he is such an one, and that in addition to producing its own more or less characteristic effects,/

effects, the shell explosion provided the stimulus required to make the patients own hysterical symptoms manifest themselves. This might well have been done by some totally different stimulus of any kind. Had the patient been knocked down by a motor, or been suddenly told that his brother had been killed, he would not, as a result, be suffering from the general symptoms of shell-shock which he now presents, but he might very well be suffering from the hysterical paralysis or the mutism which, in addition to those general symptoms, he is now showing.

This point, as I hope to show, is of immense practical importance, and I venture to think that it has hardly been sufficiently recognised, the tendency being to regard all phenomena observed in patients who are suffering, or have suffered, from shell-shock merely as symptoms which are directly and entirely due to that condition.

Aldren Turner, for example, simply classifies his cases in four groups, according to the nature of what he considers to be the most prominent "symptom". He has a "psychical" group, a "spinal" group, a "special sense" group, and a "more specialized" group, this last group including cases in which such symptoms as stammering, local palsies, etc., are prominent. (7). Without entering into criticism of this classification I am bound to say that neither here, nor in any other writings on the subject which I have seen, does sufficient stress seem to me to have been laid on the point which I have tried to make clear above, namely that many of the most striking symptoms observed, especially/

especially phenomena of a hysterical nature, are by no means to be regarded as essentially symptoms of shell-shock, but rather as incidental accompaniments or complications of it, which depend for their origin, severity, and duration, upon the psychological peculiarities of the individual patient.

This view is of great practical importance for many reasons; In the first place, it follows from it that a large number of cases must be excluded from any study which has as its object the investigation of the actual symptoms and treatment of simple shell-shock.

In this connection, I fully agree with the remarks made by Dr. Stansfield (8) that the most instructive and interesting cases to work out are those in which there is no previous psychopathic tendency, cases, that is, of shell-shock occurring in patients of as complete as possible nervous and mental stability. Anyone who has experience of the remarkable complications introduced by cases in which the patient happens to be, for example, slightly feeble-minded, or hysterical, will agree that all such, and many others, should be excluded if the essential symptoms of shell-shock proper are to be studied without confusion.

Further, this view is necessary to explain the clinical fact that many of the phenomena observed are indistinguishable from the hysterical phenomena seen in civil practice, produced in various ways, some suddenly, some gradually. It also shows that the facts observed are not altogether incompatible with the

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more modern views of hysteria,---a much-needed service.

Finally, it justifies us in treating certain symptoms shown by a given patient quite apart from his general condition, and on totally different lines.

I now pass to describe some of my cases and their treatment. My patients were under my observation and care from periods varying from one day to five or six weeks, and many were seen in circumstances which rendered full investigation and satisfactory note-taking impossible. Also, cases showing unusually severe or interesting symptoms were generally sent to my wards in addition to my ordinary share, so that my series is perhaps hardly a typical one. Out of 150 cases, therefore, of which I have satisfactory notes, and on which the foregoing observations are based, I have selected 50 consecutive admissions to the ward in which I received cases of shell-shock and functional nervous disorder. They were all admitted at a time when pretty full investigation and treatment were practicable.

Many highly interesting cases fall outside this series, but those within it show considerable variety, and yet give a fairly accurate picture of the average run of such cases; a point I wish to bring out. 44 of these cases were suffering in varying degrees from shell-shock. They presented, that is to say, such symptoms as tremor, confusion, coma, twitchings of the limbs, headache, backache, insomnia, amnesia, terrifying dreams, "sounds in the ears", fear, and exhaustion to a greater or lesser extent. With these symptoms I am not at present concerned. All the 44 recovered/

recovered sufficiently to be sent to England or otherwise disposed of, but in 10 of them, when the more general symptoms had greatly abated, and in some cases had entirely passed away, hysterical phenomena remained as follows:-- Aphonia (4), mutism (2), hyperaesthesia (1), paraplegia (1) vomiting (1) and enuresis (1).

The 6 cases who were not suffering from actual shell-shock complained of the following symptoms:-- Aphonia (2), hemiplegia (1), enuresis (2), and stammering (1).

Out of 50 cases, therefore, 34 were cases of "uncomplicated" shell-shock, and the remaining 16 were cases showing hysterical symptoms which appeared in connection with shell-shock in 10 instances, and apart from any shock, save the usual shell fire, and the nervous wear and tear of a campaign, in the other 6. Of the 34 uncomplicated cases, 14 gave upon careful investigation a history either of previous "nervous breakdown", of "nervousness" as a child, or of mental disease in the family. Of the 16 cases showing hysterical phenomena, I was able to elicit a history of previous similar attacks, of "nervousness" in childhood, or of nervous or mental disturbance in the family, in no fewer than 12.

I am now concerned entirely with this group of 16 cases. I have made it clear that I regard the shell-shock which was present in 10 of them as an incident which in no way affects their essential similarity in nature to the other 6, as regards their hysterical symptoms.

By so calling them, and by proceeding in the same breath to discuss their treatment by hypnotic suggestion, the whole question/

question of the conflicting theories as to the origin of hysteria is raised. If the Freudian view is to be accepted hypnosis is at the best merely a futil attack upon symptoms, and the real treatment of the case must proceed upon totally different lines. For the Freudian theories and their practical application, even a very limited experience has given me a great respect. I have tried them on certain cases in France, with varying results. I am bound to conclude, however, that to bring many of the cases of neurasthenia and hysteria, which I have observed on active service---I would almost say the majority of them,---into line with Freudian principles, or to treat them with success by Freud's methods is a task beyond the most enthusiastic and ingenious disciple. Several such attempts have been made, and I may mention Forsyth's paper (9) as an able exposition of the subject from this point of view.

I defend the use of hypnotic suggestion in these cases to which I am referring simply and solely on the ground that it works and works quickly, whatever the theoretical objections to its use may be. We learn from the standard works on psychanalysis that the successful treatment of a case may take anything from six months to a few years. (10). Under active service conditions this is hardly a comforting conviction under which to begin the treatment of a man who suffers from hysterical symptoms. Unless we can get him well in a much shorter time than that, he has ceased to be of use to the Army. We must, therefore, invalid him out, confine our attention to more commonplace matters, and leave/

leave to others with more leisure, the luxury of finding out that he was really "a case of unconscious homo-sexuality with well-marked anal erotism". (11).

As aphonia is one of the most common, and certainly the most widely discussed of the phenomena under consideration I shall describe in some detail my experiences with regard to it. Six cases of it occurred in the series which I am reviewing, and my procedure was as follows:-- First, as in all cases treated by hypnosis, I postponed when possible all treatment for a day or two, during which time the patient became familiar with the ward and staff, and reasonably friendly relations were established. In cases where more general and acute symptoms were present I always waited until these had in a great measure subsided. My great difficulty was to secure a place for treatment free from noise and interruption. When possible, I generally made use of an empty ward. I found that on the whole I obtained better results by not explaining matters to the patient to any great extent, but merely by assuring him of my desire to help him, and of my ability to do so, provided he was prepared to co-operate with me and to follow my instructions exactly. On receiving his assurance that he would do so, I told him that he was to stare hard at the object I was going to show him, to think of nothing else, to let his eyes shut as soon as he felt sleepy and inclined to close them, and above all, not to listen or attend to me. The object used for gazing at was either an electric flash lamp or a silver-handled letter opener. In

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all my successful cases hypnosis was induced at the first attempt, generally in under two minutes. The procedure now adopted varied with the nature of the case. In the cases of aphonia, as soon as the patient had passed into a condition of hypnosis, I moved my hands along his neck and throat, and suggested to him that he was regaining control of his voice. I then directed him to re-open his eyes and to look at me, telling him at the same time that he was still drowsy and in a state in which he would find no difficulty in doing whatever I asked him. I then told him that on no account was he to <u>try</u> to phonate, but he was simply to copy what I was going to do, assuring him that as long as he kept his eyes fixed on me he would have no difficulty. After some simple movements, such as opening the mouth and putting out the tongue, I now said:- "Ah" very quietly. The response, which varied in efficiency, I always approved as, "Quite right". I repeated this procedure, insisting on the absence of effort and strain, and upon the necessity for looking at myself, until---generally at the second or third trial, and sometimes with the assistance of a little pressure on the larynx---phonation was produced. I went through the vowel sounds in this way, keeping "e", which was invariably the most difficult, to the last. I then made the patient repeat the alphabet after me, letter by letter, always insisting on correct phonation with each letter. As the ease with which this was done increased, so did I increase the speed and the loudness with which I repeated the letters. In all my successful cases

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"v, w, x, y, z," were repeated by me and echoed by the patient at great speed and almost with a shout. I now told the patient that he was wide awake, that his voice had completely returned, and that he would have no further trouble. Six of the cases under review suffered from aphonia and were treated by me in this way, five with complete success, and one with equally complete failure. This last case is of peculiar interest to myself, because it is the only failure I have had in cases of the kind on active service, though I have treated many besides the six mentioned here. His history is of interest. The condition developed according to his own story, gradually, at a time when he was being daily exposed to heavy shell fire, and had in addition, many responsible duties to perform. He was sent to a casualty clearing station, where he was found to show no symptoms of shell shock, or, indeed, of any disease whatever, with the exception of his aphonia. This fact, coupled with his manner, which was a singularly unfortunate one, aroused a strong suspicion of malingering, and as no improvement showed itself, he was sent back to do fatigues at an advanced base. As this treatment had not the desired effect, he was sent down after some time to a base hospital. Here he suffered many things at the hands of a succession of physicians. The battery was freely applied, and he was twice put under a general anasthetic with no result. He was then transferred to my care.

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It was soon clear that he was literally obsessed by two ideas. The first, that he was suspected of malingering, and the second, that he must get to England, and would not be well until he arrived there. Several attempts to hypnotise him were unsuccessful. I had, I believe, his confidence in a very considerable degree, but it was apparently quite impossible for him to remove his attention from the ideas named for any length of time. I gave him a general anasthetic, but without success. On one occasion I asked him whether, if I promised to send him to England the next day, he thought he would get well. His whole face lit up, he jumped from his seat and nodded and smiled vigorously for some time. Thereupon, as a final effort, I told him that if he would speak to me, even only one word, I would get him sent to England forthwith, would give my opinion that he was a perfectly genuine case, would in addition give him a substantial sum of money (which I produced and laid on the table beside him) and, finally, would maintain, if he wished it, a discreet silence as to his ever having spoken at all. This highly unprofessional bargain filled him with the greatest enthusiasm, and he rose to his feet again with the air of an orator, but his utmost efforts completely failed to produce any result whatever! I did in the end send him to England with his condition unchanged. The time had arrived when he had to be sent/

sent either to England or back to duty, and, mainly on the strength of the interview recorded above, I gave him the benefit of the doubt. I am still uncertain as to whether the man was a malingerer or not, and unfortunately I know nothing of his further history, though I made every effort to find out, and he himself promised me that he would keep me informed. The whole question of malingering in connection with these hysterical phenomena---especially aphonia---is one of great importance and intense interest. A highly placed officer, who is also an eminent psychologist, told me recently of a personal experience which illustrates the difficulties with which one has to contend. He had evacuated to England a case of "hysterical deaf-mutism" and had sent him a form on which to report further progress, so that he might keep in touch with the case. He received it back unfilled up and accompanied by a letter in which the patient expressed his fear that his further progress could be of no special interest, as he had been malingering his symptoms from the beginning. He reported that he could now "hear" a little, but was still unable to "Speak". He added that, of course, he trusted to the officer's honour to make no use of this information, and concluded with the reassuring statement that the officer might publish his notes of cases without fear that he, the patient, would/

would call his statistics in question.

My own work in connection with malingerers and suspected malingerers has been considerable and hardly comes within the scope of this paper. I can only say here with regard to the cases I am reviewing that, with the exception of the one described above, I am perfectly satisfied in my own mind as to the genuine nature of all of them and that the question of possible malingering was carefully considered by me in every case. It is now one of my first considerations when any case of an "hysterical" nature is admitted to my wards and I endeavour to satisfy my mind completely on the point, during the few days after admission which, as I have said, I always like to elapse when possible before undertaking any active treatment.

I should like to make two further points in this connection. Both are obvious ones, but I confess to having had the greatest difficulty in making them clear to those of my colleagues who are unfamiliar with nervous and mental work. The first is, that the fact of a patient's symptoms disappearing under pressure of threats of punishment should they not do so, is no evidence that the patient is necessarily a malingerer. A case of which I have knowledge was cured of his aphonia by a colleague who told him that unless he recovered his voice that night he would be sent back to the trenches next day. This was regarded as conclusive evidence that the man was malingering, which of course it is not. To threaten a hysteric and to inspire him with/

with fear is not, in my view, the ideal treatment for the condition, but it is a matter of common knowledge that it is a very old-established and frequently very effective one. The second point is simply that it is in the nature of the hysteric to deceive and that the fact of a patient manipulating his thermometer with a hot water bottle or the end of a cigarette is not only perfectly compatible with his having a "genuine" aphonia, but is, in fact, almost to be regarded, in many cases at least, as evidence in favour of it. These points are, no doubt, refinements, and I am perfectly in agreement with those who say that we must import a little of the rough and ready into our treatment of hysterics, if we are to keep before us our immediate duty, namely, to get our patients ready as soon as possible for the firing line, and if we are to avoid epidemics of "Hysteria". But it is just by those who pride themselves on their clinical acumen, and their skill in detecting "scrimshankers" that these points are overlooked or ignored.

To return, however, to my cases; I have mentioned the six cases of aphonia, in five of which hypnotic suggestion proved at once efficacious. I must now discuss the two of mutism which I treated in this way. I consider these apart from the aphonics, because my small experience has led me to accept the view of Charcot that the two are entirely distinct and are not merely different in degree, which is the view of Wyllie and Bastian. The two cases I treated by hypnotic suggestion both recovered the power of speech at the first attempt, but the difference

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between them and the aphonics was to my mind very striking. Major Mott refers to the suddenness with which these mutes recover (12) but my experience with these two cases, and with others which I have treated since, has been the reverse. They certainly recovered quickly in the sense that after one sitting they were able to produce words, whereas before they had been unable to do so, but for days afterwards their speech was slow, stammering and uncertain, in contrast to the aphonics who spoke at once with ease and fluency. For all their difficulty in speech after treatment none of my mutes whispered instead of phonating clearly at any time, but their difficulty, slowness, and hesitancy irresistibly suggested something much more central than a mere aphonia, and reminded me strongly of certain cases of motor-aphasia which I have seen. This question is also discussed by Major Mott (13). I observed in these cases the anaesthesia of the pharynx described by Bastian (14) as well as the stammering which sometimes follows recovery, to which he also refers. Both my cases made excellent recoveries.

My next case was one in which stammering was the only symptom, and was that of an R.A.M.C., orderly in my own hospital who had not been exposed to shell-fire. I shall give his history in detail. He was a well-developed and healthy looking youth of nineteen. His family history was negative except for the fact that he said one of his younger brothers was delicate and took fits. He, himself, was, he said, a perfectly healthy child and not at all "nervous". His speech was perfectly normal till the

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age of nine at which time he met with an accident when on a friend's motor cycle. Immediately thereafter he began to stammer pretty badly, but rapidly improved although he underwent no special treatment, and after some months only the slightest hesitation in his speech was noticeable. This persisted, but did not cause him any particular anxiety. He says, in fact, that he soon ceased to think about it. Shortly after the outbreak of War, he joined the R.A.M.C., and was sent to a large base hospital close to the one where I am at present working. In June, 1915, while still at this hospital, he developed an attack of acute appendicitis. He was immediately operated on, and found upon recovering from the anaesthetic, that he was unable to speak without a most violent stammer. This showed no signs of improving, and had become even worse by October, when he was transferred as orderly to the hospital to which I am attached. The patient was, by this time, in a state of acute distress regarding his condition, more especially as he is a University student and hopes to become a lawyer. I was asked to try what could be done for him and took him under my observation and treatment in the month of November,

After several conversations with him, in which I elicited the above facts, and discovered in addition that he was a highly nervous and excitable youth, I gave him an outline of the treatment I proposed to adopt and secured his hearty co-operation. I then proceeded to hypnotise him, and found that he was an excellent subject, passing into deep hypnosis at the first attempt. When

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he was in this state I suggested to him repeatedly and strongly that he was regaining complete power to speak quietly and clearly, amplifying and reinforcing this suggestion in various ways. After rousing him, I at once asked him to read a passage which he had found practically impossible immediately before the sitting. He now succeeded very tolerably, the improvement being most striking. At two successive sittings the same procedure was adopted and improvement was still evident, though not so marked as on the first occasion. At this stage the patient was in the highest degree delighted at his progress, and seemed to think that it was only a question of a few days till he became perfectly well. I was not satisfied, however, that this was so, but I suspended treatment and left the patient untreated for nearly three weeks. When next I saw him he was still obviously suffering from a fairly bad stammer, but so great was the difference between his present and his former condition that he apparently counted his present disability as of small consequence, and was more than delighted with his progress. He willingly agreed, however, to further treatment, and so the sittings recommenced. This time I resolved to try what is known as the "Ab-reaction" used by Freud before he abandoned the use of hypnosis, and referred to by Brill (14). This may be briefly described as a short cut to psychanalysis. It consists in awakening the patient's memory of forgotten experiences, presumably connected with his condition, while he is under hypnosis, and expounding and explaining them to him later in the waking state, thus restoring them/

them fully to his consciousness, and permitting their due and proper emotional affect to be produced. As the patient's history gave clear indications as to where these experiences should be sought---namely, in connection with the cycle accident and the operation---I considered the case was a highly suitable one in which to adopt this method. I accordingly hypnotised him and elicited a large number of completely forgotten experiences, many of a highly painful character, connected with his operation and the time immediately preceding it. It is impossible to give these in full here, but the most important was a group of events in the few days immediately preceding his illness and operation. These consisted, first, of an intense conflict between on the one hand his moral and religious feelings and upbringing, and, on the other, his inclination to commit certain immoral acts to which some of his comrades were constantly urging him. Then came intense shame at being laughed at because of his refusal, then a most trying incident in which he was accused of having reported these comrades to a higher authority, and, finally, a breach of discipline in which he himself was concerned, which gave his comrades still more cause to make his existence miserable. Many other incidents were elicited, but as I say, the foregoing struck me as being the most important and central, and I was sure that if the key to his present condition lay in his past experiences at all it was here. I was not successful, by the way, in eliciting anything of importance in connection with the cycle accident. I dismissed the

patient/

patient without comment and told him to see me the next day. He had, of course, no recollection whatever of what he had told me when in the hypnotic state. I explained to him, as simply as possible, what I was going to do, and the reason for it, and then proceeded to take him over the facts I had elicited. It was abundantly clear that they had all been completely repressed from his memory, and it was strange to observe what I can only call the surprised recognition with which he greeted each one. When I came to the central group of facts mentioned above, he became very agitated, showed considerable emotion, and stammered badly when discussing them. I went over them all at very great length, explaining as well as I could that I wanted him to remember them clearly and face them fairly once for all, that there was nothing to be gained by refusing to admit the thing to oneself, by running away from one's own past history, or by "trying to forget", but that the road to mental and, in his case, to physical health lay in a full and untroubled recollection of all that was past, and an acceptance of, and indulgence in, whatever emotions it called forth.

The result of this interview was a most marked improvement, fully as great, I should say, as that observed on the first day of treatment. The stammer was now almost imperceptible and the patient's delight knew no bounds. He had a slight error of refraction for which I had him fitted with suitable glasses and these, he says, caused a still further and decided improvement. Two months later, he was speaking well, with a very slight/

slight hesitation which only became noticeable when he got excited, or had to address a superior officer in formal circumstances. He had a pretty sharp attack of influenza during which he became distinctly worse for a short time, but recovered as his health improved. It is quite noticeable that he speaks better when he wears his glasses, strangely enough whether he is reading or not. I regard this case as at least a partial cure, and as I consider it of unusual interest, I have reported it thus in detail.

By way of contrast I may next describe my case of hemiplegia. He was a pleasant and healthy lad whose "Army age" was twenty though he seemed much more like eighteen. He gave a negative family history, but said he was always "a bit nervous". He was admitted to my ward with a complete flaccid paralysis of left arm and leg and a marked aphonia. The tendon reflexes were present on the affected side, sensation was impaired but not altogether absent, and there was no power of motion or circumduction of the left leg. The aphonia was very marked, the patient being only able to make the very faintest whisper, and generally preferring to communicate by signs. He had been exposed to the usual shell fire, but there was no history of shell shock. I give his story as he wrote it for me, in his own words:--

"Sir,

On November 27th I dropped a shell on my left foot and it made me limp a bit. Then I did a guard and my feet got very cold/

cold and wet. I had not had dry feet for a fortnight or three weeks.

On November 28th I reported sick and our doctor said he thought I had a touch of sciatica. During the day, I gradually lost the use of my left leg, and then about 7 or 8 o'clock I had a fit (at least, I think it was a fit) and when I came round out of it, I had lost the use of my left arm.

Next day, November 29th, our doctor gave me a few pills, and I went to sleep, during the morning. When I woke up, I tried to call out for one of my chums, but somehow I could not form any words to speak. I believe I lost my head a bit then, when I found I could not speak, because after that I do not remember any more, until I saw our doctor and my chums standing talking to me.

He, the doctor, put me to bed, and the next day I was sent to hospital."

After being twelve days in Hospital without improvement, the patient was transferred to my ward. Two days thereafter I attempted treatment by hypnotic suggestion. The proceeding seemed to cause the patient considerable amusement, but he was a singularly intelligent youth and once he realised the importance of the matter, passed very readily into hypnosis at the first attempt. When he was deeply hypnotised I suggested to him that he had regained the power of his arm and leg. I repeated this frequently and forcibly, rubbing the limbs as I did so. I then woke/

woke him up, well within five minutes, I should think, from the beginning of the sitting, told him in a matter of fact way that he was now all right, and invited him to walk back with me to the ward from which we had come, instead of being carried bodily as had been necessary to bring him to the ward where the sitting took place. With much trepidation he got up and walked with the assistance of my arm back to his ward---a distance of some fifty yards---though with a distinct limp. I told him there was no need for him to go back to bed till bedtime, and in the course of the next hour or so he was walking normally about the ward. I treated his aphonia the next day in the manner described previously, with complete success.

I have grouped three of my cases under the heading fenuresis. In one case this appeared inconnection with pretty severe shell shock. In the two others there was only a history of long and adruous service in France and of heavy bombardments. These two cases presented practically identical symptoms. Both suffered from great frequency of micturition during the day, often accompanied by some abdominal pain, and from incontinence at night. Both had had previous attacks, one for years at childhood and the other on three occasions at childhood and adolescence, each lasting for some months. Both were of a highly nervous temperament. Neither of them proved good subjects for hypnosis, though I was able to get them both into a very slightly dazed and sleepy state.
Suggestions given to them when in this state produced no result whatever/

whatever in the one case, and only the very slightest improvement in the other. The general health of both men was poor and I did not feel justified in prolonging my attempts at treatment along these lines. The third case, in which there was a history of shell shock, was also unsatisfactory. The question of accommodation forced me to attempt treatment while his general symptoms were still pretty marked, and four attempts to hypnotise him were all equally unsuccessful. It is, I think, agreed that such cases when genuine, as I have no doubt these were, are most difficult ones and require very patient and prolonged treatment.

The remaining three cases of my series treated by hypnosis were one of hyperaesthesia, one of paraplegia, and one of vomiting. The first presented no particular features of interest beyond the fact that the nature of the condition---which was a well-defined "stocking" hyperaesthesia of the left foot and ankle---was at first quite overlooked. After the general symptoms of shock had passed off, and the patient's only but constant complaint was of his foot, he was first treated for rheumatism, and the condition was finally diagnosed as neuritis. He was utterly unable to walk, the hyperaesthesia being most acute on the sole of his foot, and he moved himself about the ward when out of bed with the aid of two crutches. I suggested that the condition was an hysterical one and the patient was given into my charge. He was hypnotised, with but slight difficulty, at the first attempt and I suggested

to/

to him that the pain had passed away and that he could now bear handling and pressure perfectly well. While repeating these suggestions I gradually passed my hands down from his knee till I was holding and rubbing the foot and ankle. I then roused him, having first suggested that his right hand would be quite anaesthetic when he awoke. I then told him to get up out of bed. He began to do so with much hesitation, and reached out for his crutches. I told him this was quite unnecessary as his foot was now well, adding "for that matter, I have quietened the nerves of your hand as well, so that you can feel no pain in it at all." This I demonstrated by pinching him. This surprised him a good deal, and I completed the matter by assuring him again that his foot had become perfectly normal, gripping it firmly with my hand, as I said so. This seemed to convince him, and he put his foot boldly on the floor. In a few moments he was walking down the ward, rather gingerly it is true, but without his crutches, and a short time afterwards I saw him standing on the "bad" leg in the midst of an admiring circle of comrades, who up till that time had been listening daily to his cries of pain as his foot was being dressed. I heard the patient was still well two months after this incident.

My case of paraplegia occurred in a man who had been the subject of pretty severe shell-shock. The origin of the paraplegia is of interest, in that it was not present on admission, and only made its appearance after he had been in the ward for well over a fortnight. He had been allowed up the previous day, for the first time, at his own urgent request, and, though "shaky" had/

had walked perfectly well. The paralysis was a flaccid one of the usual hysterical type. The patient was hypnotised without any difficulty, and he was able to walk, though with much difficulty and hesitation, after the first sitting, in which I had suggested to him that he had regained the power to do so. It was only after three sittings, however, on consecutive days, that he was able to walk in a normal fashion without assistance. He was very poorly developed physically, and was a highly neurotic subject. He had also a bad heredity, his mother having been insane. His paralysis did not return while he was under my care, but he was rarely without an ache or pain of some sort. As his general health was very poor, and there were signs of tubercular mischief in his lungs, I evacuated him to England not long afterwards.

The last case I shall describe was one of "hysterical vomiting".

The patient had been under heavy shell fire for some days, and had been sent immediately thereafter to a casualty clearing station with a diagnosis of "Influenza and Shell-shock". As soon as he arrived at the clearing station, he began to vomit after meals, and within a few days his condition became so bad that he vomited within half an hour of every meal, and it was only with the greatest difficulty that he could be made to retain anything at all. After four or five days he was sent down to the base and admitted to my ward. He was thin and weak, but was surprisingly cheerful, and complained of nothing except the vomiting. He was admitted very/

very late at night, and was put on a milk diet for the following day. He vomited immediately after both breakfast and dinner. As this seemed to be a case in which prompt measures were required, I decided the treat the patient at once. He was, a bright and intelligent lad of 23, with nothing of note in his family or personal history. He was well educated and had at one time been a medical student. In the afternoon of the day after admission, therefore, I spoke to him at great length along the lines practised and advocated by Dubois.

It is impossible to go into these at length here, but they are set out at length by him in his book:--"The Psychic treatment of nervous disorders", in which he explains the application of his methods to cases of aphonia, vomiting, etc. I then hypnotised the patient. He was not an easy subject, and it was only with much difficulty that a state of very light hypnosis was induced. While he was in this state I repeated much of what I had said, and suggested strongly and repeatedly that he was now better, and that his stomach would retain whatever he chose to put in it. When I roused him, he told me that he had heard my voice all the time, but had been so drowsy that he had been unable to make out the words I was saying. I told him that he would require no medicine or treatment of any kind, because he would have no further difficulty.

I then arranged that his diet be changed at once to a full ordinary one. Two hours later he ate what he said was the heartiest meal he had eaten for about a fortnight. He did not vomit/

vomit after it, nor did he ever vomit again during his stay in Hospital. He remained on full diet, gained greatly in weight and strength, was transferred to a Convalescent Camp in about ten days time, and was finally sent back, well, to duty, a few weeks thereafter.

It will be well, here, to summarize the above cases and the results of their treatment.

1.	Aphonia	Recovered.	
2.	do.	do.	
3.	do.	do.	
4.	do.	do.	
5.	do.	do.	
6.	do.	Not improved.	Failure to hypnotise.
7.	Mutism	Recovered.	
8.	do.	do.	
9.	Stammering	Much improved.	
10.	Hemiplegia.	Recovered.	
11.	Enuresis.	Not improved.	Very slight hypnosis.
12.	Enuresis.	Not improved.	Failure to hypnotise.
13.	Enuresis.	Not improved.	Failure to hypnotise.
14.	Hyperaesthesia.	Recovered.	
15.	Paraplegia.	Recovered.	
16.	Vomiting.	Recovered.	Very slight hypnosis.

The question of the after history of these at once presents itself. It has been quite impossible in the circumstances to keep in touch with them, and I can only say that I have not heard of/

of recurrence of the symptoms in any of the "recovered" cases, and that in three or four of them I have heard that they were still well some months after treatment. I do not dispute the possibility of a recurrence in any case, and am quite alive to the fact that such recurrence would be to a certain extent evidence that I have merely been treating symptoms and leaving the underlying condition untouched. It is also true that such symptoms as those I have been discussing generally pass away in time,---often fairly soon---if left untreated, but that does not alter the fact that while they exist they cause infinite trouble and distress to the patient, and render him quite unfit for military duty. A method of treatment which can remove these symptoms quickly and safely in a fair proportion of cases, and render the patients efficient fighting units again is certainly worthy of the most thorough investigation and application. Of the value of hypnotic suggestion in the earlier and more acute stages of shell shock I am as yet unconvinced, notwithstanding the brilliant work of Col. Myers along this line, but the results I have obtained have made me certain that it is the best and most satisfactory treatment for the symptoms I have described.

This paper has been prepared, and the cases described therein examined and treated, under very far from ideal conditions, and in the stress of active service. In no way does it deal exhaustively with the numberless interesting and difficult problems which inevitably arise in connection with a subject which is as yet so obscure and unexplored both as regards the etiology of the phenomena/

phenomena and the actual rationale of the treatment applied. I have found it both necessary and advisable to limit myself to an attempt firstly to discuss shell-shock, mainly from a psychological point of view, and in relation to certain phenomena observed, and secondly to give an account of some of the cases treated, the methods employed, and the results obtained.

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10. Brill. "Psychanalysis; its theory and practical application" pp. 31.

11. A case described by Forsyth in reference No. 9.

12. Proceedings of the Royal Society of Medicine. Feb, 1916, pp. XX.

13. Loc. cit. pp. xviii et seq.

14. "Aphasia and other speech defects", pp.126.

15. Brill, loc. cit., pp. 15.

Note: Reference 2 has not been consulted by me personally. I mention it, as is seen by the context, merely as the latest summary of the views held by the author, views which he has frequently put forward in other papers, to some of which I refer.